

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP        ( ) IE        ( ) IC		<b>Response Timely Filed?</b> (x) Yes    ( ) No	
Requestor's Name and Address Atlantis Healthcare Clinic, LP 6300 Samuell Blvd. #112 Dallas, TX 75228		MDR Tracking No.:                      M4-04-2895-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Ace American Insurance Co. c/o ACE USA/ESIS 9901 Brodie Ln., Ste. 160 PMB 225 Austin, TX 78748                      Box 15		Date of Injury:	
		Employer's Name:                      Taco Bell Corp.	
		Insurance Carrier's No.:                      012007026635WC01	

**PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)**

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02/10/03	03/04/03	97750-MT, 97032, 97110, 97250, 97265, & 99213-MP	\$326.00	\$177.00

**PART III: REQUESTOR'S POSITION SUMMARY**

Position Summary states in part, "...Provider sent a request for reconsideration September 19, 03. Proof that carrier received request is also included. Carrier chose not to respond within 28 day time frame rule. TWCC Rule 133.307(j)(2) says only the reason brought up by carrier can be heard at MDR...DOS 1-23-03 through 3-10-03 (97265, 99213): No EOB's have been received for these services. DOS 3-10-03-03 (97750-MT): This service has been properly documented (see attached)..."

#### PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "...The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR Code Section 413.011(d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier asserts that the charges are inconsistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately. The carrier questions whether the provider properly obtained preauth/present prior to providing the disputed services..."

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

The Requestor submitted an up-dated table on March 4, 2005. The dates of service in dispute are 2/10/03 (CPT Code 97750-MT) and 03/04/03 (CPT Codes 97032, 97110, 97250, 97265 and 99213-MP). Neither party submitted EOBs for date of service 03/04/03. Per Rule 133.307(g)(3)(A) the requestor has submitted convincing evidence of a request for reconsideration. The CPT codes used to treat the injured worker for date of service 03/04/03 will be reviewed according to the 1996 Medical Fee Guideline.

- CPT Code 97750-MT for date of service 02/10/03 denied as “N – Not appropriately documented. Medical report is required.” Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(3) the requestor has submitted the muscle testing report to support services were rendered as billed. Reimbursement in the amount of \$43.00 is recommended.
- CPT Code 97032 (2 units) for date of service 03/04/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(a)(iii) this modality requires direct, one-to-one, patient contact by the doctor. The SOAP note submitted does not document direct contact. Reimbursement is not recommended.
- CPT Code 97110 (3 units) for date of service 03/04/03. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

- CPT Code 97250 for date of service 03/04/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(c), submitted SOAP notes support services were rendered as billed. Reimbursement in the amount of \$43.00 is recommended.
- CPT Code 97265 for date of service 03/04/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(c), submitted SOAP notes support services were rendered as billed. Reimbursement in the amount of \$43.00 is recommended.
- CPT Code 99213-MP for date of service 03/04/03. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(B)(1)(b), submitted SOAP notes support services were rendered as billed. Reimbursement in the amount of \$48.00 is recommended.

#### PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$177.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Marguerite Foster

03/21/05

Authorized Signature

Typed Name

Date of Order

#### PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

#### PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_